Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
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Original Public Report

Report Issue Date: October 30, 2023	
Inspection Number: 2023-1525-0005	
Inspection Type: Critical Incident Follow up	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: Isabel and Arthur Meighen Manor, Toronto	
Lead Inspector Nicole Ranger (189)	**Inspector Digital Signature** Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.11.14 11:07:53 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 10, 12, 13, 17, 19, 20, 2023
The inspection occurred offsite on the following date(s): October 18, 2023

The following intake(s) were inspected:
- Intake: #00093600 - Critical Incident System (CIS) #3031-000047-23 - related to fall prevention and management
- Intake: #00094648 - Follow-up (FU) - related to Transferring and positioning techniques
- Intake: #00094649 - Follow up - related to Accommodation services
- Intake: #00094934 - CIS #3031-000052-23 - related to fall prevention and management
- Intake: #00096186 - CIS #3031-000057-23 - related to Disease Outbreak

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1525-0004 related to O. Reg. 246/22, s. 40 inspected by Nicole Ranger (189)

Order #001 from Inspection #2023-1525-0004 related to FLTCA, 2021, s. 19 (2) (c) inspected by Nicole

Ranger (189)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in resident #001's plan of care for fall prevention was provided to the resident as specified in the plan.

Rationale and Summary
i) Resident #001 was at risk for falls and had a history of unsteady gait. They required a fall preventions logo to identify the resident was at high risk of falls.

On an identified date, the inspector observed resident #001 seated in the tv lounge. The inspector observed the fall prevention logo was not in place on their mobility device. The inspector observed in the resident's room that the fall prevention logo was not at the head of the bed. Personal Support Worker (PSW) #105 assigned to resident #001 reported they were unaware the resident requires a fall prevention logo as they did not observe a logo on the resident's mobility device before. PSW #105 and Registered Practical Nurse (RPN) #106 observed and acknowledged that the fall prevention logo on the mobility device or fall prevention logo above the resident's head of bed were not in place.

The Director of Care (DOC) and Physiotherapist confirmed that that resident #001 remained at risk of falls and those interventions should have been in place.

There was moderate risk to the resident when the fall prevention interventions were not in place to mitigate the risk of falls.

Sources: Observation on an identified date, Resident #001's progress notes, care plan, interviews with PSW #105, RPN #106, Physiotherapist, and the DOC.

[189]

ii) The licensee has failed to ensure that the care set out in resident #001 plan of care for toileting and mobility was provided to the resident as specified in the plan.

Rationale and Summary
Resident #001 required one-person physical assistance and constant supervision for toileting and the use of a mobility device for mobility as the resident was at risk for falls. On an identified date, PSW #105 assisted the resident to the toilet and left the resident unattended. Resident #001 was found on the washroom floor by PSW #107. The resident was assessed by RPN #108 and Registered Nurse (RN) Designate #109 and transferred to the hospital for further assessment and was diagnosed with an injury.

PSW #105 reported that they were assisting resident #001 with toileting and had left the resident unattended on the toilet as they heard another resident demonstrating responsive behaviors. PSW #105 stated that the mobility device was not in the washroom with the resident at the time of the fall. PSW #105 also reported that they and PSW #110 was assisting resident #003 with care, and when they were leaving resident #003's room, PSW #107 informed them that resident #001 was on the floor in their washroom.

RPN #108 and RN Designate #109 stated that resident #001 requires one person supervision while toileting and the use of a mobility device for mobility. RPN #108 and RN Designate #109 both confirmed that the mobility device was not in place at the time of the fall and that the resident was left unattended while toileting.

The DOC acknowledged that the mobility device was not in the washroom at the time of the fall, and staff did not follow resident #001's plan of care for toileting.

Failure to ensure the care set out in the plan of care was provided to resident #001 put the resident at risk of injury from a fall.

Sources: CIS #3031-000047-23, resident #001's progress notes, care plan, home's investigation notes, interviews with PSW #105, PSW#107, PSW #110, RPN #108, Nurse Designate #109, and the DOC

[189]

WRITTEN NOTIFICATION: REQUIRED PROGRAMS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with their Falls Prevention and Management policy related to post fall management.

Rationale and Summary:

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and was complied with.

Specifically, staff did not comply with the home's policy for head injury routine, that upon discovering a resident had an unwitnessed fall, registered staff should complete a thorough assessment of the resident including a head injury routine (HIR).

Resident #002 fell on an identified date. RPN #103 reported that staff found the resident on the floor. The resident sustained an injury. A Head Injury routine (HIR) tool was started.

Resident #002 sustained two additional falls that day and was transferred to the hospital for further assessment and was diagnosed with an injury.

Review of the HIR identified that an assessment was not completed at an interval as required.

RPN #103 confirmed that the head injury routine was not completed as per policy.

The DOC acknowledged that staff did not follow the home's policy of completing the head injury routine as per schedule.

Failure to assess resident #002 after the fall in accordance with the home's policy, placed the resident at risk for further injury.

Sources: CIS #3031-000052-23, home's investigation notes, Falls Prevention Program policy 6.24. revised December 7, 2021, resident #002's progress notes; interviews with RPN #103, RPN #104, DOC and other staff.

[189]

WRITTEN NOTIFICATION: CRITICAL INCIDENT REPORTING

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee has failed to ensure that the Director was immediately informed about an outbreak of a disease of public health significance or communicable disease.

Rationale and Summary
The home went into an outbreak as declared by the Public Health Unit (PHU) on September 1, 2023. The Critical Incident Report (CIS) indicated the outbreak was declared on September 1, 2023 , however the report was first submitted to the Ministry of Long-Term Care on September 5, 2023.

The DOC acknowledged that the outbreak was declared on September 1, 2023, and was not immediately reported to the Ministry of Long-Term Care.

There was low risk to the residents as the home had initiated outbreak measures as directed by the PHU.

Sources: Critical Incident Report #3031-000057-23, interview with DOC, Assistant Director of Care (ADOC) # 102 and Infection Prevention and Control (IPAC) Lead # 111.

[189]